PRE-OPERATION VISIT
FOR
FAMILY DAY CARE HOMES

1. Provider Name _____
   Address _____
   _____
   County_____ Phone_____

2. Provider's own children:

Full Name	Age
_____	_____
_____	_____
_____	_____
_____	_____

3. Is the provider claiming his/her own children? Yes No
4. Is the provider claiming related children over capacity? Yes No
   If Yes, list children's names and relationship to the provider

Child's Name	Relationship to the Provider

5. Type of provider: ☐ Registered ☐ Certified ☐ Licensed
6. License capacity: _____ Expiration Date ___/___/___
7. Have record keeping requirements been explained to and discussed with the provider?
   ☐ Yes ☐ No
8. Is the provider willing to and capable of maintaining the required daily CACFP records?
   ☐ Yes ☐ No
9. Is kitchen equipment suitable for food service?
   ☐ Yes ☐ No
10. Is kitchen clean and well organized?
    ☐ Yes ☐ No
11. Is dining area suitable for children?
    ☐ Yes ☐ No
12. Are thermometers available for both refrigerator and freezer?
    ☐ Yes ☐ No
13. Does the provider wish to participate in the Child Care Food Program?
    ☐ Yes ☐ No
15. Describe plan for correcting deficiencies identified in this visit:
    _____
    _____
16. Has the provider ever been terminated or determined "seriously deficient" by another sponsoring organization?
    ☐ Yes ☐ No

_____ _____
Signature of Sponsor Representative Date Signature of Provider Date